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ABSTRACT

This paper discusses the importance and dangers of causal theories of sexual orientation, noting that, in recent years, the illness model of homosexuality has been thoroughly discredited and replaced with a variety of gay and lesbian affirmative constructs which explore the effects of a disparaging and hostile society on the development and psychological functioning of gay and lesbian individuals. It is suggested that, despite its legitimate therapeutic and sociopolitical drawbacks, the illness model of homosexuality included elements of causality and a sense of context that is lacking from newer theories. It is argued that, even though both biological and learning theories of the cause of homosexuality have failed in finding empirical support, biological, and especially interactional, models nonetheless have a legitimate place in scientific inquiry. The dangers attendant upon theories of causality of sexual orientation are described as lying in the liability of such theories for abuse by the medical and psychiatric profession for the sake of economic gain. The paper concludes that gay and lesbian affirmative practitioners should pursue theories about the nature and causes of sexual orientation, because of the theoretical vacuum left by the decline of the illness model and because of potential clinical utility. (TE)

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# Psychological and Ethical Implications of Causal Theories of Sexual Orientation

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PSYCHOLOGICAL AND ETHICAL IMPLICATIONS OF CAUSAL THEORIES OF SEXUAL ORIENTATION
A PAPER PRESENTED AT A SYMPOSIUM: SOCIAL AND ETHICAL IMPLICATIONS OF CAUSAL EXPLANATIONS FOR SEXUAL ORIENTATION
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I would like to offer you some observations on why I think causal theories of sexual orientation are important, as well as what dangers exist with them. My first point concerns the now discredited illness model of sexuality.

The demise of the illness model of homosexuality is a more complicated event than is readily apparent. Typically, the therapeutic implications (i.e. whether homosexuality requires a "cure" or whether gay and lesbian people are better served by affirmative therapies) and the social/political implications (i.e. civil rights vs. "treatment" of gay and lesbian people) are focused upon.

But there are some other implications of the illness model to which I would direct your attention. Despite its invalidity, the illness model was a rich and full model including elements of causality, variations and disagreement about causality, and a sense of context, i.e. assertions that homosexuality was the product of particular psychodynamic events embedded within a larger psychodynamic discourse of human behavior and motivation.

The demise of the illness model has been just that - an ending of a point of view. What has replaced it are a variety of gay and lesbian affirmative constructs which explore the effects of a disparaging and hostile society on the development and psychological functioning of gay and lesbian individuals, and some clinical applications of these ideas in therapy.

This is an impressive start and, I suspect, the "right" place to start, as it attempts to address the pressing needs of gay and lesbian clients. But, it is only a start. One of the most important current omissions is a conceptualization of what causes variation in sexual orientation.

Gay and lesbian affirmative perspectives have been suspicious of theories of causality for good reason. All the ones that have existed to date have been linked implicitly or explicitly to illness model perspectives. The deepest suspicions seem to be reserved for biologically based theories on the nature and causes of sexual orientation. Frankly, this has always struck me as odd.

The theoretical perspectives which were the underpinnings of the most disrespectful, indeed assaultive, illness model treatments for homosexuality were staunchly environmental. Both psychoanalytic and behavioral attempts to change sexual orientation assume that heterosexuality is the biological norm and homosexuality a learned developmental anomaly.

Gay and lesbian affirmative perspectives have been more alarmed by what biologically based illness models might lead to. As Charles Silverstein details in his chapter in the forthcoming volume on homosexuality sponsored by Division 9, there have been limited but egregious attempts to "eliminate" homosexuality by surgery, hormonal therapies and more recently by suggestions to manipulate fetal hormone levels. These have been every bit as unsuccessful as learning based theories in psychoanalysis and behavior modification. The lack of disconfirming data did not stop the learning based approaches for a long time, while biologically based change approaches tend to be greeted with immediate suspicion and protest - and so were much less used. I suspect this is more due to American psychology's love affair with environmental theories of causation, rather than anything more rational and considered. It would appear historically that gay and lesbian affirmative perspectives have more to fear from learning based approaches.

This discussion begs the question of why theories of causality are important. Why not just view them as too dangerous, of no useful significance theoretically or clinically, and focus on other areas?

I believe that would be an error for a number of reasons. The first is that the nature of things is always a legitimate scientific question - and the demise of the illness model has left us without many markers in this area. Diagnosis is a curious amalgam of scientific fact and scientific fashion. I would suggest to you that what happened when homosexuality was depathologized was that two necessary but each alone insufficient conditions were met. There was political muscle and will to make the change (i.e. responding to scientific fashion) and there was consistent empirical data to undermine and discredit the illness perspective (i.e. responding to scientific fact). This empirical data is summarized in my chapter of the forthcoming Division 9 book on homosexuality. It suggests that not only were there no reliable differences in psychopathology between homosexual and heterosexual populations, but there were also no consistent personality differences. The Kinsey Institute researchers in their volume a few years back concluded that there were no consistent family pattern differences between homosexual and heterosexual populations. Demographic researchers have found few sociological variables which differentiate homosexual and heterosexual populations; i.e. the now commonplace observation that sexual orientation cuts across most ways in which we divide society.

What is overlooked in this, as the illness model is given a richly deserved burial by the behavioral sciences, is that we know less

than we ever thought we did about the nature and meaning of sexual orientation.

Science understands phenomena by what their correlations. When personality, family background, pathological and demographic variables do not correlate much with sexual orientation, that means we do not know what sexual orientation is. Scientific thinking does not usually like this state of affairs. There is a distinct tendency to fill in the gaps. In other words, we know less than we think we ever did about the nature and meaning of sexual orientation. This question is a legitimate scientific one - and I believe that if gay and lesbian affirmative theoreticians do not begin to shape answers to it, someone else will.

There is another good reason for undertaking such an exploration. i believe it will be clinically useful. I have been working with gay and lesbian clients now for about 17 years through an affirmative perspective. The more I do this the more I see diversity, not cohesion, in the experience of gay men and lesbians. Not only that, I see this diversity in groups who ought to be cohesive. Let me discuss an observation is made entirely upon white middle class English speaking gay men. I have noticed the following characteristics that appear to cluster together.

Cluster 1 includes having female friends; having a tendency to be gender discordant as a child; a tendency to romanticize relationships; being psychologically comfortable with dependency in relationships; a tendency for the coming out process to be diffuse and involve a period of confusion; a tendency towards limerant reactions in romantic situations; and having a poor fit with white middle-class gay male subcultural norms. Cluster 2 consists of the opposite: having primarily male friends; no particular tendency towards gender discordance as a child; a tendency to sexualize relationships; not being comfortable with dependency in relationhips; having an abrupt, crisp coming out process; having primarily lusty responses in romantic situations; and having a better fit with gay male community norms.

I am not certain what these differences mean, or if even my observation about the clustering of these variables is correct. If there is some validity to these observations, I have also observed that these differences appear to be irrelevant to issues of greater or lesser psychological adjustment. They might suggest longstanding historically rooted predispositions to certain kinds of relationship patterns or styles -- and one which Jim Weinrich's biologically based theorizing offers some promise for understanding.

As a clinician, I feel shortchanged by the lack of gay and lesbian affirmative understandings about the nature of sexual orientation and variations within sexual orientations. As a gay affirmative clinician, I am becoming more convinced than ever when I am dealing with a demographically homogeneous group of gay men, that I am <u>not</u> dealing with a homogeneous group. There is little in gay and lesbian affirmative perspectives to guide me in making sense of this. I think this means Jim Weinrich and I will have to make

up some idea to remedy this. Actually, we're working on it.

Both biological and learning theories of causality have failed -- and rather badly at that -- to develop empirical support for themselves. When I observe the history of psychological consrtucts, it seems to me that this usually means a number of things. One might be that simplistic either or models are inadequate. In this case, this would mean that there is likely to be an interplay of biological and learning factors. Another might be that the thing being studied is not itself homogeneous; i.e., there are homosexualities and heterosexualities. Yet another might be that the entire way we are cutting the pie is all wrong, and that there are major definitional problems in our conceptualization of sexual orientation. I do not know the answer to these dilemmas, but I am convinced that they entail a serious re-examination of the nature and causes of sexual orientation.

Those are some reasons why we should take the risk of exploring gay and lesbian affirmative theories about the nature and causes of sexual orientation. But, what are the risks? All theories on the nature and causes of sexual orientation are abusable in a *minor* sense, i.e. in their misapplication. In other words, an energetic creative bigot can use any available tool. One can envision nightmare scenes of mothers dousing themselves and their fetuses with hormones in a misapplication of current biological theories, just as for years parents (usually mothers - it's remarkably consistent how they always take the rap) have been trying not to create the "wrong" family pattern.

The issue is that any theory of causality of sexual orientation is abusable in its misapplication. The best response to this is to be actively involved in developing new theories about the nature of sexual orientation and to take strong and noisy stands when attempts to misapply them are made.

There is also a risk of *major* abusability. It is much more subtle. It is the implication that value is attached to certain kinds of people. This is a hierarchical perspective which implies that if there is variation, then one aspect of variation is better than another. This major risk is harder because we are more directly confronted with the way in which science and cultural values are linked. This will require a more thoughtful examination of the implications of any new theories. One hopeful note is that a fatuous hierarchal value judgement is simply harder to do with the complex interactional theories which I suspect will eventually carry the day. There are too many components to be fit into a simplistic value system. At least, I hope so.

Let me finish up my thoughts with one I believe is somewhat novel. Psychology sometimes operates with the idea that certain *ideas* are dangerous or risky. Psychology often operates with a naivete, perhaps willful, about its own economic motivations. What I would suggest to you is that the economic abusability of any idea of causality of sexual orientation will be the best predictor of its actual risk.

Let me give you some examples. In the 1960's and early 70's, surgeons, a group not known for their conceptual risk-taking, went on a limb doing transsexual surgeries before any data were collected on what were the effects of these surgeries. After a few years, there was noted a high rate of adverse psychological reaction to the surgeries, some suggestions that the procedures did not prevent later problems, as well as other suggestions that there were few differences in outcome between those who did and did not have the procedures. A great deal of malpractice action ensued, whereupon surgeons then reverted to their typical caution. What had possessed them to be so risk-taking?

Another example exists currently. Hospital corporations, again another group not noted for their risk-taking, are rushing full tilt into developing inpatient programs for a "disease" entity which does not exist, i.e. sexual addicition, basing these programs on untested theories, and to many observers, outrageous and patently fraudulent claims. I will go out on as limb and predict that this area will have a similar course as transsexual surgery, and that there will be disappointments and law suits in coming years over this. Why are hospital corporations being so risk-taking?

Compare this to the extraordinary lack of risk taking with the depathologizing of homosexuality. Long after science has officially terminated the "diagnosis" of homosexuality, there remain practitioners who still cling to the illness model The data supporting depathologizing are as strong as anything gets in psychology. Why this conservatism and great lack of risk taking? Why are some new risky ideas about sexuality acceptable, while others are not?

What I would suggest to you is that the common factor is money. What health care providers abuse or do not abuse in the way of ideas does not depend on those ideas but on economic self-interest. Transsexual surgery and preparation for such surgery, and sexual addiction treatments promise huge profits. Depathologizing a large group of people means market shrinkage. I believe our greatest blind spots as a profession are to issues of economic injustice, class differences and economic motivation; in particular, the economic injustices in which we collaborate as a profession, the class differences our behavior supports, and our own guild-driven economic motivation.

That is where the risk lies. Theories about causality of sexual orientation will be dangerous, I will predict, in direct proportion to their econimic abusability. The ideas themselves have little to do with it.

In summary then, I would suggest the following.

1. Gay and lesbian affirmative practitioners should pursue theories about the nature and causes of sexual orientation - or someone else will - both because of the theoretical vacuum the end of the illness model has created and because of potential clincal utility.

2. Biological, especially interactional models, have as a legitimate place as anything else in scientific inquiry and it would be anti-intellectual to proscribe them.

3. The risk of abusability of any theory is linked to its economic implications, not to the nature of the ideas.

Thank you.